AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

January 10, 2012

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MA-ACA Website

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Announcements

Maternal, Infant, and Early Childhood Home Visiting Research Network, §2951. Announced January 9, 2012. Funding is available to public or nonprofit institutions of higher learning and public or private nonprofit agencies engaged in research or in programs relating to maternal and child health and/or services for children with special health care needs. The Research Network grant will support the creation of an interdisciplinary, multicenter research forum for scientific collaboration and infrastructure building related to home visiting research that is designed to improve life outcomes among mothers, infants, and young children. HRSA will make 1 award totaling $300,000 for this initiative.
Applications are due March 5, 2012.
The announcement can be viewed at: HRSA

Consumer Operated and Oriented Plan (CO-OP) Program, §1322. Announced July 28, 2011. Modified January 5, 2012. CCIIO (The Center for Consumer Information and Insurance Oversight)issued a modified grant announcement based on the 12/13/11 final CO-OP rule and to signify the start of the new grant award cycle. The program was created under the ACA to foster the creation of new consumer-governed, private, nonprofit health insurance issuers. In addition to improving consumer choice and plan accountability, the CO-OP program also seeks to promote integrated models of care and enhance competition in the exchanges established under §1311 and §1321 of the ACA. $3.8 billion is available for loans to capitalize eligible prospective CO-OPs with a goal of having at least one CO-OP in each state. Applicants that will

offer CO-OP qualified health plans on a statewide basis, will use integrated care models, and have significant private support will be given priority. To be eligible for a loan, an applicant must be a private nonprofit member organization and must intend to become a CO-OP. An organization is not eligible for a loan if it was licensed by a state as a health insurance issuer as of July 16, 2009 or it was a related entity or predecessor organization of such an issuer. An organization is also not eligible for a CO-OP loan if the organization has as a sponsor a state or local government. The first round of applications was due October 17, 2011 and are due subsequently on a quarterly basis until December 31, 2012. CCIIO expects to fund one CO-OP in each state and the District of Columbia, making 51 awards.
Read the updated grant announcement at: Grants.Gov
Read the December 13, 2011 final rule at: http://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf

Grant Activity

On December 27, 2011 the **Health Connector submitted a Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Level 1 grant application** to HHS under §1311 of the ACA. Grant funding will allow the Health Connector to invest in efforts to continue their work to develop an ACA compliant Exchange; enhance the experience, products and services for individuals and small businesses shopping for health insurance through an Exchange; and continue to engage stakeholders in Exchange planning and Establishment efforts.
The grant narrative can be viewed on our website under the Grants section at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/grants/state-operated-health-ins-exchanges.pdf

Guidance

1/5/12 HHS issued **an interim final rule with comment period, Administrative Simplification: the Adoption of Standards for Health Care Electronic Funds Transfers and Remittance Advice**. The rule, which implements parts of §1104 of the ACA, requires the adoption of a standard for electronic funds transfers (EFT), defining EFT and explaining how the adopted standards support and facilitate health care EFT transmissions. Standards have been streamlined for the format and data content of the transmission a health plan sends to its bank when it wants to pay a claim to a provider electronically (through an EFT). The rule establishes a tracking system to automatically match up a bill and the corresponding payment when a provider submits a claim electronically for payment. HHS estimates that this will reduce up to $4.5 billion off administrative costs for doctors and hospitals, private health plans, states, and other government health plans, over the next ten years. The regulation is effective January 1, 2012 and all health plans covered under HIPAA must comply by January 1, 2014. Comments are due March 12, 2012.

Read the rule at: http://www.gpo.gov/fdsys/pkg/FR-2012-01-10/pdf/2012-132.pdf

These standards build upon regulations published in June 2011 that set industry-wide standards for how health providers use electronic systems to more efficiently determine a patient's eligibility for health coverage and check on the status of a health claim. Combined, HHS projects that the two Administrative Simplification regulations will save the health care industry more than $16 billion over the next 10 years. The savings are derived from the adoption of electronic standards that will help eliminate inefficient manual processes and reduce costs.

For more information on the **HIPAA Administrative regulation: Adoption of Operating**

Rules for Eligibility for a Health Plan and Health Care Claim Status, visit: http://www.hhs.gov/news/press/2011pres/06/20110630a.html

1/3/12 The Internal Revenue Service issued Notice 2012-9 which provides **guidance to employers under §9002 of the ACA on informational reporting to employees of the cost of their employer-sponsored group health plan coverage** on their annual W-2. Notice 2012-9 restates and clarifies previous guidance (Notice 2011-28), including the information on how to report, what coverage to include and how to determine the cost of the coverage. The notice also resolves additional questions raised by employers and makes clear that employers can- but are not required to- report contributions to health reimbursement arrangements in calculating health care costs. In addition, the cost of providing coverage through employee assistance programs, wellness programs or on-site medical clinics is not required to be reported if the employer does not charge premiums for the coverage to COBRA beneficiaries. The notice also states that until further guidance is issued, the reporting requirement will not apply to tribally chartered corporations wholly owned by federally recognized Indian tribal governments.

Last fall the IRS issued guidance (Notice 2010-69) which made the ACA requirement for employers to report the cost of coverage under an employer-sponsored group health plan optional for all employers in tax year 2011. Guidance released in spring 2011 (Notice 2011-28) provided further relief for smaller employers filing fewer than 250 W-2 forms by making the reporting requirement optional for them at least for 2012 and continuing this optional treatment for smaller employers until further guidance on that matter is issued.

The 2011 Form W-2 is available for viewing on IRS.gov at: Form W-2
The form includes the codes that employers may use to report the cost of coverage under an employer-sponsored group health plan.

Read Notice 2011-28 at: http://www.irs.gov/pub/irs-drop/n-11-28.pdf

Read IRS Notice 2012-9 at: http://www.irs.gov/pub/irs-drop/n-12-09.pdf

Prior guidance can be viewed at www.healthcare.gov

News

1/6/12 CCIIO finalized the list of companies that have been granted **temporary waivers from the ACA's restrictions on annual benefit caps**. A total of 1,231 companies applied for and received waivers that will allow them to gradually raise their benefit limits caps until 2014, when all annual limits will become prohibited by the ACA. These organizations received a temporary exemption by certifying that a waiver is necessary to prevent either a large increase in premiums or a significant decrease in access to coverage. In addition, these "mini-med" (or limited benefit) plans are required to inform their enrollees that their plan does not meet the coverage requirements of the ACA. According to HHS, the number of enrollees in plans with annual limits waivers is approximately 3.9 million people, representing less than 3% of Americans with private health coverage. HHS denied 96 waiver requests. Denied applicants did not demonstrate that compliance with the minimum annual limits requirements would significantly increase premiums or decrease access to benefits.

To see a breakdown of the types of applicants and learn more, visit CCIIO's website: http://cciio.cms.gov/resources/files/approved_applications_for_waiver.html

1/4/12 HHS/CCIIO rejected a request from Oklahoma for a waiver which would have allowed insurers in that state to phase in the ACA's medical loss ratio (MLR)

requirements. **1/4/12 HHS rejected a similar request from the state of Kansas**.

The ACA allows the Secretary to adjust the medical loss ratio (MLR) standard for a state if it is determined that meeting the 80% MLR standard may destabilize the individual insurance market. In order to qualify for this adjustment, a state must demonstrate that requiring insurers in its individual market to meet the 80% MLR has a likelihood of destabilizing the individual market and result in fewer choices for consumers. As part of the ACA, if insurers fall short of the standards in 2011, they'll have to issue rebates for that amount in 2012.

Oklahoma requested an adjustment of the MLR standard to 65%, 70%, and 75% for reporting years 2011, 2012, and 2013, respectively. CCIIO found that all issuers in the state's individual market either 1) already meet the 80% MLR standard, 2) intend to price their products to meet the 80% MLR standard, and/or 3) are sufficiently profitable to absorb the impact of rebate payments under an 80% MLR standard. As a result CCIIO determined that no adjustment to the MLR standard in Oklahoma is necessary because there is not a reasonable likelihood that any of the issuers in the state may leave the market.

Kansas requested an adjustment of the MLR standard to 70%, 73%, and 76% for the reporting years 2011, 2012, and 2013, respectively. CCIIO determined that no adjustment to the MLR standard in Kansas is necessary because there is not a reasonable likelihood that any of the issuers in the state may leave the market. CCIIO found that all issuers in the Kansas individual market either already meet the 80% MLR standard, or are adapting their business models in order to comply with it and continue to perform financially.

HHS has approved waivers for Georgia, Iowa, Kentucky, Maine, Nevada, and New Hampshire. HHS has denied requests from Florida, Michigan, Indiana, Louisiana, North Dakota and Delaware. In September HHS denied Guam's request saying the rules in question don't apply to the insurance markets in Guam. The other states that have applied and are awaiting determinations include: Texas, North Carolina and Wisconsin. For more information on states and the MLR requirements visit the Center for Consumer Information and Insurance Oversight (CCIIO) website at: http://cciio.cms.gov/programs/marketreforms/mlr/index.html

EOHHS News

The public comment period on MassHealth's draft Demonstration Proposal on Integrating Medicare and Medicaid for Dual Eligible Individuals closes at 5pm on 1/10/12. Under this proposed Demonstration authorized under ACA§ 2602, MassHealth and CMS will use combined Medicare and Medicaid funding to contract with integrated care organizations to provide integrated, comprehensive care, including MassHealth and Medicare benefits, plus diversionary behavioral health benefits and additional long term services and supports.

The draft Demonstration Proposal is posted at www.mass.gov/masshealth/duals under "Related Information" and on Comm-PASS (www.comm-pass.com).

***Written comments must be received by EOHHS by 5 pm, January 10, 2012.**

Comments may be sent to: duals@state.ma.us, or mailed to:
Executive Office of Health and Human Services
Attn: Lisa Wong
One Ashburton Place, Rm. 1109
Boston, MA 02108

Upcoming Events

Three R's Workgroup (Reinsurance, Risk Adjustment and Risk Corridors) Stakeholder Meeting
Wednesday, January 18, 2012
10 AM - 12 PM
Room 1-E, Division of Insurance
1000 Washington Street, Boston, MA

If any interested persons are unable to attend the meetings in person, they can participate in the session by calling the number below.
Dial 1-877-820-7831
Pass Code 371767# (please make sure to press # after the number)

Money Follows the Person (MFP) Working Group
Thursday, February 2, 2012 from 2 PM - 3:30 PM
Saxe Conference Room
Worcester Public Library
3 Salem Square
Worcester, MA

Please contact MFP@state.ma.us to attend the MFP meetings and to request reasonable accommodations.

More information on MFP can be found at: Money Follows the Person

Bookmark the **Massachusetts National Health Care Reform website** at: http://mass.gov/national health reform to read updates on ACA implementation in Massachusetts.

Remember to check http://mass.gov/masshealth/duals for information on the **"Integrating Medicare and Medicaid for Dual Eligible Individuals"** initiative.